California Medicine

# EDITORIAL

## Welcome NMA

WE EXTEND A WARM WELCOME to the National Medical Association which will hold its 74th Annual Convention August 10 to 14 in San Francisco. Elsewhere in this issue Julius W. Hill, the California physician who will be installed as the next president of the NMA, has given a most valuable account of the need for this organization, its growth, and particularly the important work that its component branches are doing in California. He notes that "almost one hundred percent" of the members of the Golden State Medical Association are also members of the California Medical Association.

One senses that the time is approaching when Negro physicians and Negro patients will become completely assimilated into the mainstream of medicine and then there will no longer be a need for a separate National Medical Association. This will be a truly great and important moment in the history of American medicine. We hope that it will come sooner and not later. In the meantime we wish the NMA well, and especially congratulate Dr. Hill and wish him a successful and productive term of office.

## Portal Hypertension

ELSEWHERE IN THIS issue of CALIFORNIA MEDICINE is a review of the current status of portal hypertension by Richard P. Anderson and Earl F. Wolfman, Jr. There are probably few current medical subjects that evoke greater controversy. Partly responsible for this are the patient, and institutional and geographical differences that exist with this disease. Whereas alcoholism is associated with the majority of cases of cirrhosis in this country, this is not the case in Great Britain, Africa and the Asiatic countries. Whereas cirrhosis is responsible for the great majority of cases of portal hypertension in this country and Europe, schistosomiasis and hepatoportal sclerosis (idiopathic portal hypertension) are more common in certain Asiatic and Arabic lands. And the disease in the indigent charity hospital patient generally behaves in a different fashion than in the well-to-do private patient. It thus becomes more understandable why successful treatment given to a patient in one area may not succeed in another setting.

While in agreement with the general outline and with the majority of the views expressed by the authors, I disagree with some of them. It will be recognized that this disagreement represents only a personal opinion and reflects the divergence of opinion which is literally world wide.

A classification of portal hypertension satisfactory to all has not yet been devised, and that outlined by the authors has its deficiencies. It is suggested that obstruction to portal venous inflow is congenital (cavernous transformation, atresia and stenosis) or due to thrombosis secondary to pylephlebitis following neonatal omphalitis or intra-abdominal infection. In fact, the causes are not known. Further, the evidence that pylephlebitis plays an etiologic role is so tenuous that it should be discarded. It is attractive and logical to think that an hepatic artery portal vein arterio-